

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155738</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILTON HOME, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>206 E MARION ST</b> <b>SOUTH BEND, IN 46601</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/09/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/09/14</p> <p>Facility Number: 001141 Provider Number: 155738 AIM Number: 200905640</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this PSR survey, Milton Home was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility with a basement is fully sprinklered and was determined to be of Type II (111) construction. The original building was constructed in 1952 with the nursing addition located on the first and second floors added in 1975. The facility has a fire alarm system with smoke detection in the corridors, in resident sleeping rooms on the second floor and in all areas open to the corridor. Resident sleeping rooms on the first floor have battery operated smoke detectors. The facility has a capacity of 34 and had a census of 25 at the time of this survey.</p>	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	Continued From page 1 Quality Review by Lex Brashear, Life Safety Code-Medical Surveyor on 12/15/14.	{K 000}			